STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395066	A. BLDG: 00 B. WING:	04/14/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
JEFFERSON HILLS HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: **100202**	**448 OLD CLAIRTON ROAD JEFFERSON HILLS, PA 15025**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification Survey, State Licensure Survey, Civil Rights Compliance Survey, and Abbreviated Complaint Survey completed on April 14, 2023, it was determined that Jefferson Hills Healthcare and Rehabilitation Center was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations as they relate to the Health portion of the survey process.	F 0000		
F 0575 SS=C		F 0575		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0575 SS=C	Continued from page 1 483.10(g)(5)(i)(ii) Required Postings §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by:	F 0575	0575 I. The facility will display the contact information (name, address, email address, and phone number) for the local state agency, Adult Protective Services, Medicare/Medicaid Fraud unit, legal information, and a statement that the resident may file a grievance with the Social Security Administration in areas accessible to residents on two of two nursing units (Nursing unit floor 1 and Nursing unit floor 2). II. Moving forward, the facility will display the contact information (name, address, email address, and phone number) for the local state agency, Adult Protective Services, Medicare/Medicaid Fraud unit, legal information, and a statement that the resident may file a grievance with the Social Security Administration in areas accessible to residents. III. Director of Operations will re-inservice Nursing Home Administrator to display the contact information (name, address, email address, and phone number) for the local state agency, Adult Protective	Completion Date: **06/06/2023** Status: **APPROVED** Date: **05/05/2023**

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F 0575 SS=C	Continued from page 2	F 0575	Services, Medicare/Medicaid Fraud unit, legal information, and a statement that the resident may file a grievance with the Social Security Administration in areas accessible to residents. IV.Nursing Home Administrator to audit required postings once a week for 8 weeks to ensure all postings are posted. V. Review of required postings will be conducted during the quarterly QAA meetings.	

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F 0575 SS=C	Continued from page 3 Based on observations and staff interview it was determined that the facility failed to display the contact information (name, address, email address, and phone number) for the local state agency, Adult Protective Services, Medicare/Medicaid Fraud unit, legal information, and a statement that the resident may file a grievance with the Social Security Administration in areas accessible to residents on two of two nursing units (Nursing unit floor 1 and Nursing unit floor 2). Findings include: During observations the following was noted : 4/14/23: at 9:29 a.m., on 2nd floor nursing unit (to include lounge area) - no postings of the following were observed: contact information (name, address, email address, and phone number)for the local state agency, Adult Protective Services, Medicare/Medicaid Fraud unit, legal information, and a statement that the resident may file a grievance with the Social Security Administration.	F 0575		

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F 0575 SS=C	Continued from page 4 4/14/23: 9:37 a.m., on 1st floor nursing unit (to include lounge area): no postings of the following were observed: contact information (name, address, email address, and phone number)for the local state agency, Adult Protective Services, Medicare/Medicaid Fraud unit, legal information, and a statement that the resident may file a grievance with the Social Security Administration. 04/14/23: at 9:42 a.m., in entry way postings for contact information (name, address, email address, and phone number)for the local state agency, Adult Protective Services, Medicare/Medicaid Fraud unit, legal information, and a statement that the resident may file a grievance with the Social Security Administration. During an interview on 4/14/23, at 2:43 p.m., the Nursing Home Administrator confirmed that the facility failed to post in areas accessible to all to all residents the contact information (name, address, email address, and phone number) for the local state	F 0575		

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F 0575 SS=C	Continued from page 5 agency, Adult Protective Services, Medicare/Medicaid Fraud unit, legal information, and a statement that the resident may file a grievance with the Social Security Administration. 28 Pa. Code: 201.29(i) Resident rights.	F 0575		
F 0582 SS=D	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the	F 0582	I. Nursing Home Administrator will conduct a 30 day look back to ensure those residents who required a SNFABN received one. II. Moving forward, the facility will issue required SNFABN's. III. Nursing Home Administrator will re-educate RNAC that notices of Medicare non-coverage SNFABN are to be issued timely. IV. RNAC will conduct weekly audits of all discharges for 8 weeks to ensure that notices of Medicare non-coverage SNFABN are issued timely. Results will be taken through QAA for tracking and trending purposes.	Completion Date: **06/06/2023** Status: **APPROVED** Date: **05/05/2023**

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F 0582 SS=D	Continued from page 6 facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by:	F 0582		

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F 0582 SS=D	Continued from page 7 Based on review of facility documentation and staff interview it was determined that the facility failed to ensure that notices of Medicare non-coverage SNFABN were provided timely for one of two residents (Resident R24). Findings include: Review of Resident R24's Medicare Non - Coverage information indicated that Resident R24 was to receive a SNFABN. Review of facility documentation indicated that resident did not receive a SNFABN. During an interview on 4/14/23, at 10:50 a.m. Registered Nurse Assessment Coordinator (RNAC) Employee E1 confirmed that Resident R24 did not receive a SNFABN. 28 Pa. Code: 201.18(e)(1)Management.	F 0582		
F 0584 SS=E		F 0584		

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F 0584 SS=E	Continued from page 8 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all	F 0584	I. Maintenance Director and designee to address all concerns observed during survey – Loose baseboards observed during survey will be reattached with adhesive. New blinds will be purchased. Any walls/closets/entrances with exposed plaster observed during survey will be sanded down and painted. All screens replaced in all windows. Holes in walls observed during survey will be patched and/or covered with new drywall and repainted. The national distributor for the cooling unit was contacted – these units do not come with a bottom panel. Broken chair rails observed during survey will be removed/replaced to ensure resident safety. All shower drains will be sprayed and cleaned thoroughly. New flooring to be ordered to replace missing areas. Patching to be made to the areas in front of the nursing stations to ensure sturdiness. Toilet seats observed to be loose will be put into locked position. Faucets identified to be loose during survey will tightened	Completion Date: **06/06/2023** Status: **APPROVED** Date: **05/05/2023**

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F 0584 SS=E	Continued from page 9 areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 0584	down and made secure. All air conditioners on Awing private rooms to be wiped down/ filters to be removed and washed. II. Maintenance director or designee to do a facility sweep to ensure all toilets and faucets are tighten down/ any exposed plaster to be sanded and painted/ all windows to be tested for functioning window clips / flooring will reviewed for any other areas of needed replacement. IV. Nursing Home Administrator will educate Maintenance Director on homelike environment, Housekeeping Manager will be educated on using trash can liners, Therapy Manager will be educated on cleaning equipment in between residents. V. Moving forward the Director of Maintenance will complete monthly rounds to ensure home like environment is maintained. VI. Housekeeping Manager to audit for 5 rooms weekly for 8 weeks to ensure trash liners are in garbage cans. Therapy Manager to audit 5	

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F 0584 SS=E	Continued from page 10	F 0584	residents a week for 8 weeks to ensure equipment is being cleaned in between residents. Results will be taken through QAA for tracking and trending purposes.	

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F 0584 SS=E	Continued from page 11 Based on review of facility policy, observations, and resident and staff interviews, it was determined that the facility failed to maintain a clean, homelike environment in one of two shower rooms (Nursing Unit C wing (first floor) shower room), the main hallway floor by the nurses station of the B nursing unit and one of three resident/visitors bathrooms (A Wing bathroom), and for 21 of 72 residents (Residents R32, R40, R184, R64, R182, R25, R11, R63, R47, R54, R21, R34, R7, R45, R44, R39, R183, R8, R37, R38 and R51) and the therapy room. Findings include: Review of the facility policy " Homelike Environment ", last reviewed on 8/1/22, indicated that the facility staff and management provides a comfortable and homelike environment with adequate lighting and a clean sanitary environment in all areas. During observations on 4/12/23 at 8:30 a.m.	F 0584		

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F 0584 SS=E	Continued from page 12 During an interview on 4/12/23, at 9:35 a.m., the Nursing Home Administrator confirmed that the facility did not maintain a safe clean comfortable homelike environment for 17 of 72 residents. 28 Pa. Code: 207.2(a) Administrator's responsibility. 28 Pa. Code: 201.29(j) Resident rights.	F 0584		
F 0585 SS=E		F 0585		

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F 0585 SS=E	Continued from page 13 483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance	F 0585	I. The facility will establish a grievance official and post the grievance policy in a prominent location in the facility. II. Nursing Home Administrator will hold and attend the next Resident Council meeting to discuss the grievance process. Moving forward, the grievance process will be reviewed during the Resident Council Meeting. III. Director of Operations will re-educate the Nursing Home Administrator that the facility is required to establish a grievance official and post the grievance policy in a prominent location in the facility. IV. Nursing Home Administrator to audit posting of grievance policy once a week for 8 weeks to ensure all postings are posted. V. Review of required postings will be conducted during the quarterly QAA meetings.	Completion Date: **06/06/2023** Status: **APPROVED** Date: **05/05/2023**

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F 0585 SS=E	Continued from page 14 can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the	F 0585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395066	A. BLDG: __00_____ B. WING: _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
JEFFERSON HILLS HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: **100202**	**448 OLD CLAIRTON ROAD JEFFERSON HILLS, PA 15025**

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F 0585 SS=E	Continued from page 15 date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by:	F 0585		

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F 0585 SS=E	Continued from page 16 Based on observation, review of facility policy, and interviews with staff, it was determined that the facility failed to establish grievance policy that identified a grievance official and post the grievance policy in a prominent location in the facility. Findings include: During the group interview on 4/13/23, at 3:00 p.m. the group indicated they were unaware of who the grievance officer was and did not know about a posting. A tour of the facility on 4/14/23, revealed no policy or procedure posted for residents or family to file a grievance. During an interview on 4/14/23, the Nursing Home Administrator confirmed that the facility failed to have a grievance policy that identified a grievance official, and post the grievance policy in a prominent location in the facility. 28 Pa. Code 201.18(b)(3)Management	F 0585		

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F 0609 SS=D	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 0609	. Nursing Home Administrator will conduct a full investigation on R17 to rule out neglect and/or abuse and report if indicated. II. Facility will conduct a 30 day look back on all incidents to insure documentation, resolution, and response was completed. Moving forward, facility will thoroughly investigate, resolve, document and report incidents. III. Nursing Home Administrator will re- in service Director of Nursing on fully investigating, documenting, reporting all incidents. IV. Nursing Home Administrator will audit all incidents weekly for 8 weeks to rule out neglect and/or abuse and report if indicated.. Results will be taken through Quality Assurance Meeting for tracking and trending purposes.	Completion Date: **06/06/2023** Status: **APPROVED** Date: **05/05/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0609 SS=D	Continued from page 18 Based on review of facility policy, facility submitted documentation, clinical records, and staff interview, it was determined that the facility failed to make certain allegations of abuse and neglect, including injury of unknown origin, are thoroughly investigated and report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within five working days of the incident to describe the results of the investigation, for one of three residents. (Resident R17). Review of the facility policy "Abuse and Neglect" last reviewed on 8/1/22, indicated that the nurse will assess the individual and document related findings. The nurse will report the findings to the physician and along with staff and management, will identify if situation could be construed as neglect. The situation will be investigated and the management team will report the identified abuse/neglect timely. During a review of the facility identified incidents and	F 0609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0609 SS=D	Continued from page 19 accidents dated from 9/22, through 4/23, three residents had concerns of "other" incidents. When reviewed Resident R17 had and incident indicating she had ingested "a small amount" of 1/4 strength Dakin's solution antimicrobial cleanser composed of water and sodium hypochlorite(caustic chemical that can cause poisoning, the breakdown indicated an acid and salt) being used for her wounds. Resident R17 was transferred to the emergency room for evaluation. Review of he facility submitted documents dated from 4/21/22, through 4/13/23, did not include a report related to this incident. During an interview on 4/14/23, at 12:11 p.m. the Director of Nursing indicated that the incident was not reported as required. 28 Pa. Code: 201.14(a)(c)(d)(e) Responsibility of licensee. 28 Pa. Code: 201.18(e)(1) Management.	F 0609		

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F 0610 SS=D	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 0610	I. Nursing Home Administrator will conduct a full investigation on R17 identified incidents to rule out neglect and/or abuse. II. Facility will conduct a 30 day look back on all incidents to insure documentation, resolution, and response was completed. Moving forward, facility will thoroughly investigate, resolve and document incidents. III. Nursing Home Administrator will re-educate Director of Nursing on fully investigating, documenting, reporting all incidents. IV. Nursing Home Administrator will audit all incidents weekly for 8 weeks to rule out neglect and/or abuse. Results will be taken through Quality Assurance Meeting for tracking and trending purposes.	Completion Date: **06/06/2023** Status: **APPROVED** Date: **05/05/2023**

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F 0610 SS=D	Continued from page 21 Based on review of facility policy, facility documents, resident and staff interview, it was determined that the facility failed to investigate two incidents with potential and actual injury resulting in neglect for one of four residents (Resident R17). Findings include: Review of the facility policy "Abuse and Neglect" last reviewed on 8/1/22, indicated that the nurse will assess the individual and document related findings. The nurse will repot the findings to the physician and along with staff and management, will identify if situation could be construed as neglect. The situation will be investigated and the management team will report the identified abuse/neglect timely. Review of he facility policy "Accidents and Incidents" last reviewed on 8/1/22, indicated that all accidents and incidents involving residents, staff visitors and vendors, etc., occuring on the premises be investigated and reported.	F 0610		

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F 0610 SS=D	Continued from page 22 During a review of the facility identifed incidents and accidents dated from 9/22, through 4/23, three residents had concerns of "other" incidents. When reviewed Resident R17 had and incident indicating she had ingested a "small amount of 1/4 strength Dakin's solution (an antimicrobial cleanser composed of water and sodium hypochlorite(caustic chemical that can cause poisoning, the breakdown indicated an acid and salt) being used for her wounds. Resident R17 was transferred to the emergency room for evaluation. During an interview on 4/14/23, at 12:11 p.m. the Director of Nursing, her statement indicated that she "did not know how Resident R17 obtained the solution as a full investigation had not been completed. 28 Pa. Code:201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(e)(1) Management.	F 0610		

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F 0660 SS=D		F 0660		

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F 0660 SS=D	Continued from page 24 483.21(c)(1)(i)-(ix) Discharge Planning Process §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences.	F 0660	I. Social Services Director will conduct a facility sweep of all current short term residents to ensure the social services discharge planning record portion is complete. Social Services Director will conduct a facility sweep of all current short term residents to ensure there is a discharge care plan specific to the residents need. II. Moving forward, Social Services Director will complete the discharge planning portion of the clinical record and a specific discharge planning care plan for all residents. III. Nursing Home Administrator will re-educate Social Services Director to provide discharge planning that focuses on the resident's discharge goals and preparation of residents to be active partners in the discharge planning process that focuses on the resident's discharge planning and process. IV. Nursing Home Administrator will audit all new admissions weekly for 8 weeks to ensure the social services discharge planning record	Completion Date: **06/06/2023** Status: **APPROVED** Date: **05/05/2023**

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F 0660 SS=D	Continued from page 25 (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant	F 0660	and discharge care plan are complete. All results will be taken through QAA for tracking and trending purposes	

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F 0660 SS=D	Continued from page 26 resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by:	F 0660		

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F 0660 SS=D	Continued from page 27 Based on review of facility policy, clinical record review, and interview with staff, it was determined that the facility failed to provide discharge planning that focuses on the resident's discharge goals and preparation of residents to be active partners in the discharge planning process that focuses on the resident's discharge planning and process for one of four residents (Resident R68). Findings include: Review of facility policy " Discharge Summary and Plan" dated 8/01/22, indicated that "When a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment." Review of Resident R68's clinical record indicated that resident was admitted on 1/23/23, with the following diagnosis Peripheral Vascular Disease (slow and progressive circulation disorder) and severe sepsis with septic shock (when the infection	F 0660		

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F 0660 SS=D	Continued from page 28 causes organ damage). Review of Resident R68's clinical record social service note indicated that Resident R68 received a NOMNC (Notice of Medicare Non-Coverage - a form given prior to discharge) on 4/13/23. Further review of the clinical record of the social service discharge planning dated 1/23/23, was blank with no information on the discharge plan. Review of clinical record indicated that a care plan for discharge planning specific to resident needs was not completed. During an interview on 4/14/23, at 11:27 a.m. Nursing Home Administrator confirmed that the facility failed to provide discharge planning that focused on resident's goals and preparation of residents to be active partners in the discharge planning process that focuses on the resident's discharge planning and process for Resident R68.	F 0660		

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F 0660 SS=D	Continued from page 29 28 Pa. Code 201.25 Discharge Policy. 28 Pa. Code 211.11(d)(e) Resident care plan. 28 Pa. Code 201.18(e)(1)(2)(3)(6)Management.	F 0660		
F 0684 SS=D	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	I. Order Obtained for R67 for Eucerin Cream to be started BID per order from wound care. II. Director of Nursing to audit all Residents on wound care to ensure all physician orders are in and being followed. III. Director of Nursing to re-educate all licensed nursing staff on following physician orders. IV. Director of Nursing will conduct 5 random audits weekly for 8 weeks to insure physician treatment orders were followed. Results will be taken through Quality Assurance Meeting for tracking and trending purposes.	Completion Date: **06/06/2023** Status: **APPROVED** Date: **05/05/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395066	A. BLDG: __00_____ B. WING: _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
JEFFERSON HILLS HEALTHCARE AND REHABILITATION CENTER	**448 OLD CLAIRTON ROAD JEFFERSON HILLS, PA 15025**
STATE LICENSE NUMBER: **100202**	

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F 0684 SS=D	Continued from page 30 Based on observations, review of the clinical record, and interview with staff it was determined that the facility failed to follow physicians orders for one of four residents (Resident R67). Findings include: Review of Resident R67's clinical record indicated that resident was admitted on 8/1/22, with the following diagnosis hypertension (blood pressure that is higher than usual) and peripheral vascular disease (slow and progressive circulation disorder) , and personal history of diabetic foot ulcer (infection ulceration, or destruction of tissue the foot). These diagnosis remained current as of the MDS (minimum data set - a brief assessment of resident needs) dated 3/2/23. During an observation on 4/12/23, at 2:07 p.m. Resident R67 was observed in wheelchair with no socks or shoes on with a visible wound on the back of heel, with skin that appeared cracked, and dry.	F 0684		

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F 0684 SS=D	Continued from page 31 Review of Resident R67's clinical record wound notes dated 3/1/23, indicated that the resident should receive Eucerin cream to feet and heels. Further review of the clinical record failed to include this on the physican orders. This was not included on the Nurse Aide task sheet to complete during ADL's. During an interview on 4/14/23, at 12:49 p.m. Assistant Director of Nursing(ADON) confirmed that the facility failed to start the Eucerin cream, for Resident R67 and failed to follow physician orders. 28 Pa. Code 201.18(b)(1)Management. 28 Pa. Code 211.12(d)(1)((3)(5) Nursing services.	F 0684		
F 0689 SS=E		F 0689		

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F 0689 SS=E	Continued from page 32 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	I. Upon notification of incident, R17, resident was transferred to the hospital for further evaluation and returned to the facility the same day with no new orders received. R17 had no adverse effect from consuming the Dakin's solution. R11 was provided thickened liquid during medication administration utilizing pre-thickened water as provided by kitchen with no adverse effects. Laundry chute on the A wing nursing unit was immediately locked and bathroom door locked. There have not been any incidents related to the laundry chute. II. Dietary manager will ensure pre-thickened liquids are provided to the nursing department on a daily basis. III. Director of Nursing will re-educate licensed employees on medication/treatment administration. Dietary manager will re-educate dietary staff on providing thickened liquids. Maintenance director will re-educate staff on locking of laundry chute. IV. Director of Nursing will conduct	Completion Date: **06/06/2023** Status: **APPROVED** Date: **05/05/2023**

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F 0689 SS=E	Continued from page 33	F 0689	random audits weekly for 8 weeks of medication/treatment administration, thickening of liquids to ensure policy is followed. Maintenance director will conduct random audits of laundry chute being locked appropriately weekly for 8 weeks. All results will be taken through the Quality Assurance Meeting for tracking and trending purposes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0689 SS=E	Continued from page 34 Based on review of the facility policies, clinical record reviews, observations and staff interviews, it was determined that the facility failed to provide necessary supervision and an environment free of accident hazards, to ensure that caustic chemicals were not accessible, resulting in transfer to hospital for one of four Residents (Resident R17), and potential choking hazards for one of three residents (Resident R59) and safety hazard on one of three nursing units (Nursing unit A second floor) with unlocked, unattended laundry chute. Findings include: Review of the facility policy " Wound care" last reviewed on 8/1/22, indicated that only disposable supplies be taken into the resident room and to discard any disposable unused items in designated proper container. During a review of the facility identified incidents and accidents dated from 9/22, through 4/23, three residents had concerns of "other" incidents.	F 0689		

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F 0689 SS=E	Continued from page 35 Review of an incident that occurred on 9/4/22, indicated that Resident R17 had ingested "a small amount" of 1/4 strength Dakin's solution antimicrobial cleanser composed of water and sodium hypochlorite(caustic chemical that can cause poisoning, the breakdown indicated an acid and salt) being used for her wounds. Resident R17 had to be transferred to the hospital for evaluation. During an interview on 4/14/23, at 12:15 p.m., Resident R17 stated that the nurse brought in the Dakin's solution in a clear water cup and placed it on her overbed table beside her water glasses and after she completed the wound care, she left he glass and Resident R17 stated she drank the Dakin's solution not realizing it and then quickly drank a lot of water. Resident R17 told the nurse and he facility sent her to the hospital for evaluation. During an attempted interview with the identified nurse, she did not answer call and did not return call.	F 0689		

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F 0689 SS=E	Continued from page 36 During an interview on 4/14/23, at 12:50 p.m. with Licensed Practical Nurse (LPN) Employee E4 stated that she only takes equipment in that is needed and removes all unused items upon leaving room. During an interview on 4/14/23, at 1:08 p. m., Registered Nurse Employee E5 and LPN Employee E6 stated that they take only supplies in that are needed and remove all equipment and unused supplies in garbage and remove. During an interview on 4/14/23, at 1:10 p.m., LPN Employee E7 stated that she removes all supplies from room after wound care is completed. During an observation on 4/14/23, at 12:46 p.m. in the [illegible] not thickened liquids. [illegible] During an observation on 4/13/23, at 8:40 a.m. LPN Employee E8 stated that she uses thickener for Resident 11 for her water for med pass as she requires nectar thickened liquids, asked how she knew how much to add, LPN Employee E8 stated	F 0689		

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F 0689 SS=E	Continued from page 37 that she gets thickener from kitchen and adds to water. Did not answer how much is used. LPN Employee E8 was not observed thickening Resident R11's water, she went to the kitchen and obtained a glass of thickened water for Resident R11's medication administration. During an interview on 4/13/23, at 8:50 a.m. the Nursing Home Administrator confirmed that nursing staff should not be thickening liquids, that the kitchen thickens the liquids before sent up and extra thickened liquids are sent up to the units for resident consumption. During an observation on 4/12/23, at 9:30 a.m. the laundry chute in the A wing nursing unit bathroom was found unlocked, with locking bar hanging off the side of chute and the bathroom door was unlocked and open allowing potential accident to occur if a resident would attempt to enter the chute. During an observation on 4/13/23, at 7:45 a.m. the	F 0689		

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F 0689 SS=E	Continued from page 38 laundry chute in a bathroom of the C wing nursing unit was unlocked, propped open with swivel lock and the door to the bathrrom was open allowing potential accident to occur if a resident should attempt to enter the chute. During an interview on 4/14/23, at 7:48 a.m. Maintenance Employee E9 confirmed that he chute is to be locked unless in use then locked afterwards and staff have access to the key. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(e)(1) Management. 28 Pa. Code: 207.2(a) Administrator's responsibility. 28 Pa. Code: 211.10(d) Resident care policies.	F 0689		
F 0740 SS=D		F 0740		

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F 0740 SS=D	Continued from page 39 483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by:	F 0740	I. R32 provided with the facility smoking times. II. Director of Nursing will ensure staff are scheduled to accommodate resident smoking times daily. III. The Director of Nursing will re-educate staff on facility smoking times. IV. The Director of Nursing will conduct random audits weekly for 8 weeks to ensure smoking times are being followed with results taken through the facility Quality Assurance Meeting for tracking and trending purposes.	Completion Date: **06/06/2023** Status: **APPROVED** Date: **05/05/2023**

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F 0740 SS=D	Continued from page 40 Based on review of facility documents, review of the clinical record, and resident and staff interview it was determined that the facility failed to identify and meet residents highest practicable psych-social needs for one of four residents (Resident R32). Findings include: Review of the facility "smoking policy", last reviewed on 8/1/22, indicated that residents smoking times are posted and staff will assist residents to smoking area and monitor them. During a review of Resident R32's clinical record, a progress note dated 3/28/23, indicated that the Social Worker Employee E22 had a "discussion" with Resident R32 regarding her "bugging him and other staff" to go out to smoke. During an interview with Resident R32 on 4/14/23, at 9:20 a.m., indicated that staff are not always available and when asked they say "no" they won't take residents out to smoke. Resident R32 stated	F 0740		

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F 0740 SS=D	Continued from page 41 she is the only resident that will speak up but also stated that that is he only thing "to look forward to and it helps with her anxiety". Review of Resident R32's plan of care identified the diagnoses of anxiety and depression as well as indicated the smoking and need for supervision and an apron. During an interview on 4/14/23, at 9:45 a.m. the Nursing Home Administrator confirmed that the facility failed to meet the needs of smoking residents and for Resident R32 to maintain her highest practicable psycho-social needs. 28 Pa. Code 211.10(a)Resident care policies. 28 Pa. Code 211.16(a)Social services.	F 0740		
F 0812 SS=F		F 0812		

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F 0812 SS=F	Continued from page 42 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	I. Four bags of chocolate chips, four concentrated juices and one bag of hamburger buns were immediately discarded. II. Dietary manager will ensure all food is stored/dated appropriately. III. The dietary manager will re-educate dietary staff on appropriate storage of food. IV. Dietary manager will conduct random audits weekly for 8 weeks to ensure food is stored appropriately with results taken through the facility Quality Assurance Meeting for tracking and trending purposes.	Completion Date: **06/06/2023** Status: **APPROVED** Date: **05/05/2023**

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F 0812 SS=F	Continued from page 43 Based on review of facility policies, observations and staff interviews, it was determined that the facility failed to properly store, label, and date food in the dry storage room and to have the second-floor refrigerator at a safe temperature for food storage to prevent the potential of food-born illness. Findings include: The facility policies "Food Receiving and Storage" review date 8/1/2022, indicated that foods shall be stored removed from original packaging, labeled and dated (use by date). Such foods are rotated on a first in first out. Policy also states that refrigerated foods are stored at or below 41 degrees Farenheit. During an observation on 4/12/23, at 9:00 a.m., dry storage room revealed four bags of chocolate chips with a best by date of 7/22, four concentrated orange juice with a best by date of 4/5/23 and one bag of hamburger buns with visible green mold growing on the buns.	F 0812		

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F 0812 SS=F	Continued from page 44 During an observation on 4/12/23, the second-floor pantry refrigerator temperature was at 54 degrees Farenheit and had milk and milk products. Observation of the second-floor refrigerator also revealed one pint of milk with a best by date of 3/23/23. During an interview on 4/12/2023, at 2:00 p.m., Certified Kitchen Manager Employee E10 confirmed that the facility failed to make certain food items were stored correctly, and the pantry refrigerator maintained a safe temperature to prevent the potential for food-borne illness. 28 Pa. Code: 211.6(c)(d)(f) Dietary services.	F 0812		

Certified End Page

JEFFERSON HILLS HEALTHCARE AND REHABILITATION CENTER

STATE LICENSE NUMBER: 100202

SURVEY EXIT DATE: 04/14/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY